

EXHIBIT A

DEATH TRANSCRIPT

DATE FILED THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE

JUL-14-2024 10:08 AM

CERTIFICATE OF DEATH

Certificate No. 156-24-029481

1. DECEDENT'S LEGAL NAME DAVID F GREENBERG

(First, Middle, Last, Suffix)

Place Of Death	2a. New York City	2c. Type of Place	4 <input type="checkbox"/> Nursing Home/Long Term Care Facility	2d. Any Hospice care in last 30 days	2e. Name of hospital or other facility (if not facility, street address)
	2b. Borough Manhattan	1 <input type="checkbox"/> Hospital Inpatient 2 <input type="checkbox"/> Emergency Dept./Outpatient 3 <input type="checkbox"/> Dead on Arrival	5 <input type="checkbox"/> Hospice Facility 6 <input checked="" type="checkbox"/> Decedent's Residence 7 <input type="checkbox"/> Other Specify	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown	110 Bank St Apt 6F, New York, NY 10014-2171
Date and Time of Death or Found Dead	3a. (Month) July	(Day) 12	(Year-yyyy) 2024	3b. Time 2:13	4. Sex Male
				<input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	5. OCME Case No. M24021168
6. CAUSE OF DEATH	PART I	a. Immediate cause Hypertensive And Atherosclerotic Cardiovascular Disease			
		b. Due to or as a consequence of			
		c. Due to or as a consequence of			
PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Include operation information.					
7a. Injury Date (mm dd yyyy)	7b. Time <input type="checkbox"/> AM <input type="checkbox"/> PM	7c. At Work 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	7d. Place of Injury – At home, factory, street, etc.		
***			7e. Location		
7f. How Injury Occurred					
7g. If Transportation Injury Specify <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Other Specify		8. Manner of Death <input type="checkbox"/> Pending further study <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Undetermined		9. Autopsy <input type="checkbox"/> Yes <input type="checkbox"/> No Autopsy Pursuant to Law <input checked="" type="checkbox"/> No Autopsy	
10. On the basis of examination and/or investigation, in my opinion, death occurred due to the causes and manner as stated: Certifier Signature <i>Michael Caplan</i> D.O. Date JUL-14-2024 Certifier Name (Print) MICHAEL CAPLAN Medical Examiner (Medical Investigator) (Deputy Chief) (Chief) (Medical Examiner)					
11a. Usual Residence State New York	11b. County New York	11c. City or Town New York	11d. Street and Number 421 E 26th St	Apt. No.	ZIP Code 10016-9161
12. Date of Birth (Month) (Day) (Year-yyyy) May 06 1942		13. Age at last birthday (years) 82	14. Social Security No. *****		
15a. Usual Occupation (Type of work done during most of working life. Do not use "retired") Professor		15b. Kind of business or industry Education	16. Aliases or AKAs ***		
17. Birthplace (City & State or Foreign Country) Evanston, IL		18. Education (Check the box that best describes the highest degree or level of school completed at the time of death) 1 <input type="checkbox"/> 8th grade or less; none 4 <input type="checkbox"/> Some college credit, but no degree 7 <input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) 2 <input type="checkbox"/> 9th – 12th grade; no diploma 5 <input type="checkbox"/> Associate degree (e.g., AA, AS) 8 <input checked="" type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD) 3 <input type="checkbox"/> High school graduate or GED 6 <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS)			
19. Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	20. Marital/Partnership Status at time of death 1 <input type="checkbox"/> Married 2 <input type="checkbox"/> Domestic Partnership 3 <input type="checkbox"/> Divorced 4 <input type="checkbox"/> Married, but separated 5 <input checked="" type="checkbox"/> Never Married 6 <input type="checkbox"/> Widowed 7 <input type="checkbox"/> Other, Specify		21. Surviving Spouse's/Partner's Name (prior to first marriage) (First, Middle, Last) ***		
22. Father/Parent Name (Prior to first marriage) (First, Middle, Last) Louis Greenberg		23. Mother/Parent Name (Prior to first marriage) (First, Middle, Last) Mina Lazar			
24a. Informant's Name Marty Hecht		24b. Relationship to Decedent Nephew	24c. Address (Street and Number Apt. No. City & State ZIP Code) 1306 Sunnyside Ave, Highland Park, IL 60035-2840		
25a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Entombment 4 <input type="checkbox"/> City Cemetery 5 <input type="checkbox"/> Other Specify		25b. Place of Disposition (Name of cemetery, crematory, other place) Liberty Grove Crematory			
25c. Location of Disposition (City & State or Foreign Country) Old Bridge, NJ			25d. Date of Disposition mm dd yyyy 07 29 2024		
26a. Funeral Establishment All Boro Cremation Services			26b. Address (Street and Number City & State ZIP Code) 1289 Forest Ave Staten Island, NY 10302-2322		

Changes approved for filling by the Commissioner of Health. Formerly: Disposition Method - Interim; approved by Deputy City Registrar J. Hicks on Jul-29-2024; Formerly: Decedent Middle Name - Blank; approved by Deputy City Registrar J. Hicks on Jul-24-2024; No further entry beyond this point.***

EVT202408399133

VR 16 (Rev. 01/20)

This is to certify that the foregoing is a true copy of a record on file in the Department of Health and Mental Hygiene. The Department of Health and Mental Hygiene does not certify to the truth of the statements made thereon, as no inquiry as to the facts has been provided by law.

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Gretchen Van Wye
Gretchen Van Wye, PhD, City Registrar



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August 20, 2024

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

